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Briefing

Health promoting prisons – An impossibility for women prisoners in Africa?

Rachael Dixey, Sharon Nyambe, Sally Foster, James Woodall and Michelle Baybutt

abstract

The health needs of women in sub-Saharan African prisons are both neglected and poorly understood. Outside South Africa, little research exists on African prison health; what is available tends to be gender-blind and concerned with disease prevention rather than with health promotion. While Vetten (2008) has raised this concern previously, a comprehensive overview of women's health and health promotion in African jails is clearly absent. Available evidence shows that the conditions in African prisons are harmful to health, justifying a need for a health promoting prisons agenda rooted in the needs of sub-Saharan Africa. Women prisoners have significant mental and physical health needs, and international conventions on health care are not being respected globally. The health promoting prison concept has considerable attention in the Global North, with a commitment to equivalence of health care, gender sensitivity and to prisoners' social as well as health needs. This article provides an opportunity for critical reflection on women's health in prison, shows the lack of research in this area, questions the suitability of the health promoting prisons' agenda for sub-Saharan Africa, draws on our limited experience of the women's prison in Lusaka, Zambia, and produces recommendations to tackle women's health and wellbeing needs within the criminal justice systems of sub-Saharan Africa.

keywords

women prisoners' health, health promoting prisons, sub-Saharan Africa

Prisoner health

Global data show that prisoners have multiple health and social needs; women suffer more ill-health than men in prison, with high rates of self harm and debilitating mental health issues (Ginn, 2013). Women prisoners have higher rates of sexual, emotional and physical abuse and mental health issues, such as depression and anxiety, than women in the general population (Baybutt, 2013). Incarceration can have a profound effect on children, whether they are in prison with their mother, or at home (Codd, 2008). Some of the most neglected, misunderstood and unseen women in society are those in prisons, disproportionately drawn from populations that are unemployed, educationally disadvantaged, living in poverty, in poor housing, in debt and with a history of abuse. Globally, male and female prisoners come from

more deprived, socially excluded backgrounds and tend to experience unequal distribution of resources, including health (Douglas *et al*, 2009; DeViggiani, 2012).

Prison health has been little studied in Africa, and where it has, the focus has been on infectious disease containment, especially HIV and tuberculosis (TB), and especially in relation to men (Angora *et al*, 2011; Baussano *et al*, 2010). Even in South Africa, little research exists about prison health services (Sifunda *et al*, 2006). A special edition of the *Prison Service Journal* explicitly set out to dispute that “prisons in Africa are too difficult to study or that their systems are too undeveloped to warrant comparison” and to put “both those myths to bed” (Jefferson and Martin, 2014:2); it highlights the human rights abuses and pitiful conditions in African prisons. Inadvertently however, it reinforces the invisibility of women, and of health, as scant attention is paid to either.

The invisibility of women prisoners and their health

In the Global North gender *is* visible in the criminal justice system and in criminology (Heidensohn, 2006), but women’s needs are still overlooked in a system dominated by men’s needs, with prison a “masculinist” penalty (Baybutt, 2013:18). In both the affluent Global North, and the Global South, women continue to be extremely marginalised, to experience the “double deviance” faced by women who commit crime, punished by both the criminal justice system and by informal sanctions from society (Heidensohn, 2006:2), and to suffer injustice based on gender, as described in Zimbabwe and South Africa by Phillips (2006). Women confront penal authorities with a multiplicity of needs different from those of the male population that prisons were originally designed for (Scott and Codd, 2010).

The assumption that inmates are male is shown, for example, in a South African doctoral thesis (Moshoeu, 2010) which talks throughout of ‘inmates’ without specifying gender. Male inmates are more commonly studied, with a few exceptions such as Dastile (2013) who tells women’s stories. Thus Sifunda *et al* (2006:2303) state,

“Male inmates were targeted for the study as they make up about 97% of the prison population in South Africa.”

Whereas ‘masculinity’ is being used as an explanatory framework to understand men’s criminality and experiences of prison life in Africa (Egelund, 2014; Nyambe, 2014), the same cannot be said of ‘femininity’ or of women’s different means of coping with incarceration.

Two peer-reviewed journals (*Journal of Correctional Healthcare*, and the *International Journal of Prison Health*) are devoted to prison health in the Global North. However, women often appear marginalised, invisible or, they are ‘like men...but different’. A literature review on prisoner health notes:

“Clearly, women prisoners are a separate category but in terms of the present review, they appeared to have many of the same problems as male prisoners but often to a greater extent” (Watson *et al*, 2004:6).

Seeing women as a sub-category, a deviation from the male-norm, fails to capture women’s experiences or needs. Hek (2006) and the World Health Organisation (WHO) (1995) note that prisoners’ voices in general are missing, thus losing the views of prisoners and prison staff in health promotion strategies. The United Nations Rules for the Treatment of Women

Prisoners and Non-Custodial Means for Women Offenders (the Bangkok Rules) have since been adopted by the United Nations to address this gap (United Nations [UN], 2010).

Rare studies *have* focused on the views of female prisoners about health (Smith, 2002; Plugge *et al*, 2008), but only in the Global North. Women's gender-specific needs are paid scant attention; Shaw *et al*'s (2015) systematic review of imprisoned pregnant women shows that they are particularly vulnerable with little known about their maternity care experiences or outcomes.

If women's views and their health needs are marginalised in the Global North, they are more so in sub-Saharan Africa. Severe threats to health exist for *both* sexes:

"The appalling physical conditions of African prisons, along with inadequate food and nutrition and almost non-existent health services, seriously exacerbate the prevalence of HIV inside prisons" (United Nations Organisation on Drugs and Crime [UNODC] and UNAIDS, 2006:17).

South African women prisoners' stories are captured by Landau (2004), Dirsuweit (1999) and Gibbons (1998), but these studies are few and far between. That women's health experiences are neglected is asserted by Todrys *et al* (2011a; 2011b) writing about Zambia, van den Bergh *et al* (2009) and Fazel and Baillargeon (2011) about prisons generally. Ashdown and James (2010) focus on female prisoners' health globally, including Africa. Aday-Amoakoh (2012) reports the appalling conditions for women in African prisons; mixed jails mean that women are subject to abuse and rape from male inmates or staff, undignified and inhumane treatment in regard to menstruation and pregnancy, overcrowding, and abuse of human rights. Vetten (2008) describes women in African prisons generally, mentioning access to health care, managing menstruation, pregnancy and childcare, violence and abuse, and drawing together evidence on the lack of personnel qualified to provide mental health services, lack of screening services for breast, ovarian and cervical cancer, high rates of long standing, untreated diseases, and high rates of mental illness, including attempted suicides. Samakaya-Makarati (2003 in Vetten, 2008) documents the appalling management of menstruation in Zimbabwean prisons, described by Vetten (*ibid.*:143) as "cruel, inhuman and degrading". Modie-Moroka and Sossou's (2001) qualitative study in Botswana of six women's prisons shows requirements could not be met for healthy lives, let alone for pregnant women, with inadequate nutrition, fresh air, recreational facilities, and sanitary conditions.

The Bangkok Rules (UN, 2010) require that women prisoners must be comprehensively screened for health problems and their health needs identified on arrival in prison. The Rules approved in 2010 by the United Nations, sets standards for women's specific health needs in incarceration which need to be adhered to. Rule 12 dealing with mental health states that,

"individualised, gender-sensitive, trauma-informed and comprehensive mental health care and rehabilitation programmes shall be made available for women prisoners with mental health care needs in prison or in non-custodial settings" (United Nations [UN], 2010).

Further, Todrys *et al* (2011b) highlight states' obligation to comply with regional law: The Southern African Development Community (SADC) Protocol on Gender and Development, which many member countries have signed, commits states to ensure that hygiene and sanitary facilities are provided for women and that their nutritional needs are met, including

women in prison, by 2015. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa passed in 2003 by the Organisation of African Unity, requires that women held in detention are held in an appropriate environment for their condition and that they are treated with dignity.

The Zambian situation

Zambian prisons should not be singled out – no doubt poor conditions are to be found throughout Africa, but the authors have experience of prisons in Zambia and Sharon Nyambe (second author) visits Zambian prisons regularly in her work there. Prisons in Zambia have been described as unjust, unhealthy and sites of human rights abuses, as “death traps” where prisoners are imperilled (Human Rights Watch, 2011: 4;) and subjected to the ‘double sentence’ of imprisonment and acquiring HIV (Simoooya *et al*, 2001). Lusaka Central Prison was designed to hold 240 (male) inmates but now holds 1, 200. HIV infection rates are reported to be 42% and 27% respectively across Zambia’s 54 custodial prisons and 33 open-air prisons (Republic of Zambia, 2011). Overcrowding is widespread: official capacity is 8,000 but the prison population is actually 20,000. Homosexual activity is illegal in Zambia and condoms are not made available; many men acquire HIV inside prison. Simply holding, feeding and sheltering prisoners takes all the available resources, with nothing for occupational activities, education, rehabilitative activities or any of the usual aspects of prison life in wealthy countries.

Men’s health in Zambian prisons is discussed in policy circles, mainly due to the moral panic surrounding homosexuality and the spread of HIV and TB, but there has been little attention to women’s health needs. Currently female prisoners have an HIV prevalence rate of 43% (Simoooya and Nawa, 2011). (that of the general population is 13%) according to the 2013-2014 Zambia Demographic Health Survey (Central Statistical Office *et al*, 2014) In Lusaka Central Prison, there are between 70 and 100 women, some with children up to the age of four. The women’s compound is physically and symbolically an after-thought, utilising a piece of land outside the inner walls but inside the perimeter walls. It appears as a make-shift space: the Catholic Church built the first dormitory for women, from an old rations store. The compound can be ankle deep in rainwater, though this problem has now reportedly been rectified. It does not have the same prison feel of the men’s space, which is *designed* as a space for incarceration. Rather, the women’s space does not look unlike a poor village neighbourhood, except for the high mesh fences and locked gates. The only maximum-security prison for women in Zambia is in the town of Kabwe. As in many other countries, the paucity of women’s jails means that family and friends have to travel long distances in order to visit.

Evidence from our research, and social workers and aid workers working with the women in prison suggest that their crimes are ‘minor’, or related to domestic violence. Most women are imprisoned for drug related offences (3-5 years for first time offences and a maximum of 10 years for repeat offenders), manslaughter (3 years) or murder (life sentence at the Kabwe Maximum prison) and theft by a public servant (6 months to 1 year). Some women are in prison because they have attacked their husbands after a period of infidelity. HIV campaigns have targeted the practice of multiple concurrent partners in poster campaigns. The stress and abuse faced by women as a result of male partners’ behaviour, and that sometimes results in women’s imprisonment, is highlighted in several research studies in Zambia (Aidoo and Harpham, 2001; Mwape *et al*, 2014). There are no studies of women in Zambian prisons that explore how they found themselves there, what they feel

about being in prison, or what happens to them on release. Not much is known about their health needs, let alone their psycho-social needs. In the authors' experience, due to their socio-economic backgrounds, women sent to prison have poor health status. Nutrition, sanitation, ventilation and hygiene and quality of water are reported by Todrys *et al* (2011b) in the only study on the health and human rights of women in Zambian prisons to be poor and inadequate. The study findings in four prisons (ibid.) reported that "Women are underserved by general healthcare programs including those offering tuberculosis and HIV testing" and found "physical and sexual abuse conducted by police and prison officers that could amount to torture under international law". Women who do not have relatives to provide toiletries and food are forced to go without such daily necessities. It is common for women to have to trade prison work for the most basic of items e.g. food and soap. There is an urgent need to build the capacity of female prisoners through targeted social and livelihood interventions in prisons and to link them to entrepreneurial projects or opportunities once released from prison.

Health promoting prisons

The health promoting prison concept has emerged to address prisoners' health. The idea that prisons *can be* health promoting is highly problematic, something we have described elsewhere as an oxymoron or a contradiction in terms (Woodall, 2010; Woodall and Dixey, 2015), and our discussion of the 'health promoting prison' should be seen within a critical questioning of whether prisons can *ever* be 'healthy' or 'life affirming'. However, until alternative ways of creating societies where the most marginalised are not sucked into a criminal 'justice' system, there will be a need to ameliorate the conditions facing inmates and thus to attempt at least to make the prison environment as healthy as possible.

The concept of 'health promoting prisons' has been evident in public health and health promotion discourse for two decades (WHO, 1986). The idea has gained increasing momentum, particularly in Europe and the United States of America (USA) (WHO, 2007; WHO, 2014; Weinstein, 2010). Prisoners' rights are at the core of the initiative. In 1966 the United Nations (UN, 1966) stated that every citizen has the right to the highest attainable standard of physical and mental health and, in 1990, they declared that prisoners should have access to health services available in the country without discrimination based on their legal status (UN, 1990). Linked to prisoners' rights is the principle that individuals detained in prison must have the benefit of care equivalent of that available to the general public (Niveau, 2007). Indeed, a period of incarceration can be seen as a time when many prisoners receive help for their health concerns, making the availability of good prison health care services essential. South Africa is not typical of African countries, with relatively sophisticated prison governance and policy structures, and it is the only African state to move towards health promoting prisons; it recognises that health care must go further than addressing medical problems to create conditions that *promote* the well-being of inmates, but *its own* guidelines are *not* being followed in terms of what health care and health promotion should be provided (Artz *et al*, 2012).

In summary, resource-rich countries have seen major policy changes to make health services provide equivalent care to prisoners as to the general population; health promoting prisons are not simply about equivalent health care, but provide opportunities to promote the health of a 'captive population'. Liebling (2012) has argued that prisons are places where mental and emotional health needs, and health behaviours can be addressed, *and* an environment provided such that people emerge from prison as healthier individuals. Woodall

and Dixey (2015) call for increased global efforts to consider whether this is the case, and how to meet the health needs of prisoners.

Towards health justice for women prisoners

In the Global North, gender-specific facilities have become an aspiration, though experiments in designing prison facilities to meet women's needs have not been fully realised (Hayman, 2006). Initiatives have tried to occupy women in prison and to attend to psycho-social needs (Baybutt, 2013), and to the needs of both older and younger women (Handtke, 2015; Douglas and Plugge, 2008). Even so, women's prisons are described as being in "crisis" (Silverstri and Crowther-Dovey, 2008:39) due to the high rates of self-harm and mental distress, adding that far from 'healthy prisons', these places at:

"best neglect the needs of prisoners and at worst add to the hopelessness, helplessness, and desperation experienced by many prisoners made vulnerable through their incarceration" (Scruton and Moore 2004, in Silverstri and Crowther-Davey, 2008:39).

The whole premise that prison is the right place for female offenders thus requires interrogation.

To increase justice for women, it needs to be recognised that 'high needs' do not always equate with 'high risk' and that many female offenders do not pose a risk to the public. Prison as punishment is a colonial import, and it can be debated whether there are other traditional forms of 'punishment' better suited to post-colonial Africa. Women's crimes in sub-Saharan Africa and elsewhere are often related to their gender, such as attempting abortion, infanticide, adultery, or to domestic situations, often in response to abuse, such as murder or attempted murder of intimate partners or other men (Sarkin, 2012; Modie-Moroka and Sossou, 2001).

We therefore suggest that what is needed is more research on women's experiences in prisons in Africa, and especially on their health and psycho-social needs. Secondly, more advocacy is needed on women's needs in prisons to ensure that those needs are given a higher priority. These priorities include the provision of health services within prisons that are geared to women's needs and which at the very least offer equivalence of care to that provided outside prison, and enforcement of the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Means for Women Offenders (the Bangkok Rules). In addition to that enforcement is the need to adapt the existing guidance on how to create suitable women's prisons, to suit the African context (Atabay, 2008; van den Bergh, 2011; UNAIDS, 2014). It would follow from the latter that there could be development of the health promoting prisons concept within sub-Saharan Africa, making sure it is relevant to the sub-Saharan African context.

In the longer term, there is a need to reform criminal justice systems to take into account the poor social and economic circumstances of female offenders; initiatives to tackle the roots of poverty, the social determinants of health and of pathogenic and criminogenic environments. Such reform would necessarily need to involve debating the role and purpose of imprisonment within sub-Saharan African society, within a critique of imprisonment as part of the colonial legacy, discussion of alternatives to custody and a questioning of the high rates of imprisonment within certain parts of sub-Saharan Africa.

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